Washington State Health Care Innovation

A Five-Year Plan

Ensuring a Whole-Person Approach

August 22, 2013

Agenda

- **Welcome & Innovation Planning Overview**

  Karen Merrikin, Project Director, SHCIP

- **Why Focus on Integration of Physical & Behavioral Health?**

  Chris Imhoff, Director, Division of Behavioral Health & Recovery, DSHS

- **Systems Support for Integrated Physical & Behavioral Health Care**

  Jonah Frohlich, Manatt Health Solutions

- **Roles Beyond the Health Care System**

  Jenny Hamilton, HCA
  Jonathan Seib, Strategies 360
  Tom Byers, Cedar River Group

- **Questions & Feedback**

- **Next Steps**

Welcome & Innovation Planning Overview

Karen Merrikin, Project Director, SHCIP

- A veteran of health policy around payment and care delivery
- Hired from the private sector to lead the state planning process

What are "SIM" and "SHCIP"?

SIM

The **State Innovation Models** initiative is a national effort and grant program of the Center for Medicare and Medicaid Innovation (CMMI) to identify and spread health practices that result in **better health and better care at lower costs.**

SHCIP

Washington State was one of three states awarded a nearly **$1 million model pre-testing grant** to fund collaborative development of a five-year plan for health innovation. Other states have received "model design" grants, and are engaged in similar work. The effort is called: **State Health Care Innovation Planning**

Where We've Been & Where We're Going

"As-Is" environment

- Gathering information from various "streams" of inquiry

"To be" environment – the potential future

- Identifying:
  - Key focus areas and strategies for transformation
  - The "levers" to move transformation forward *(activities, tools, policies, legislative adjustments)*
  - Performance measures needed to assess the value of the reforms

SCHIP Work Streams

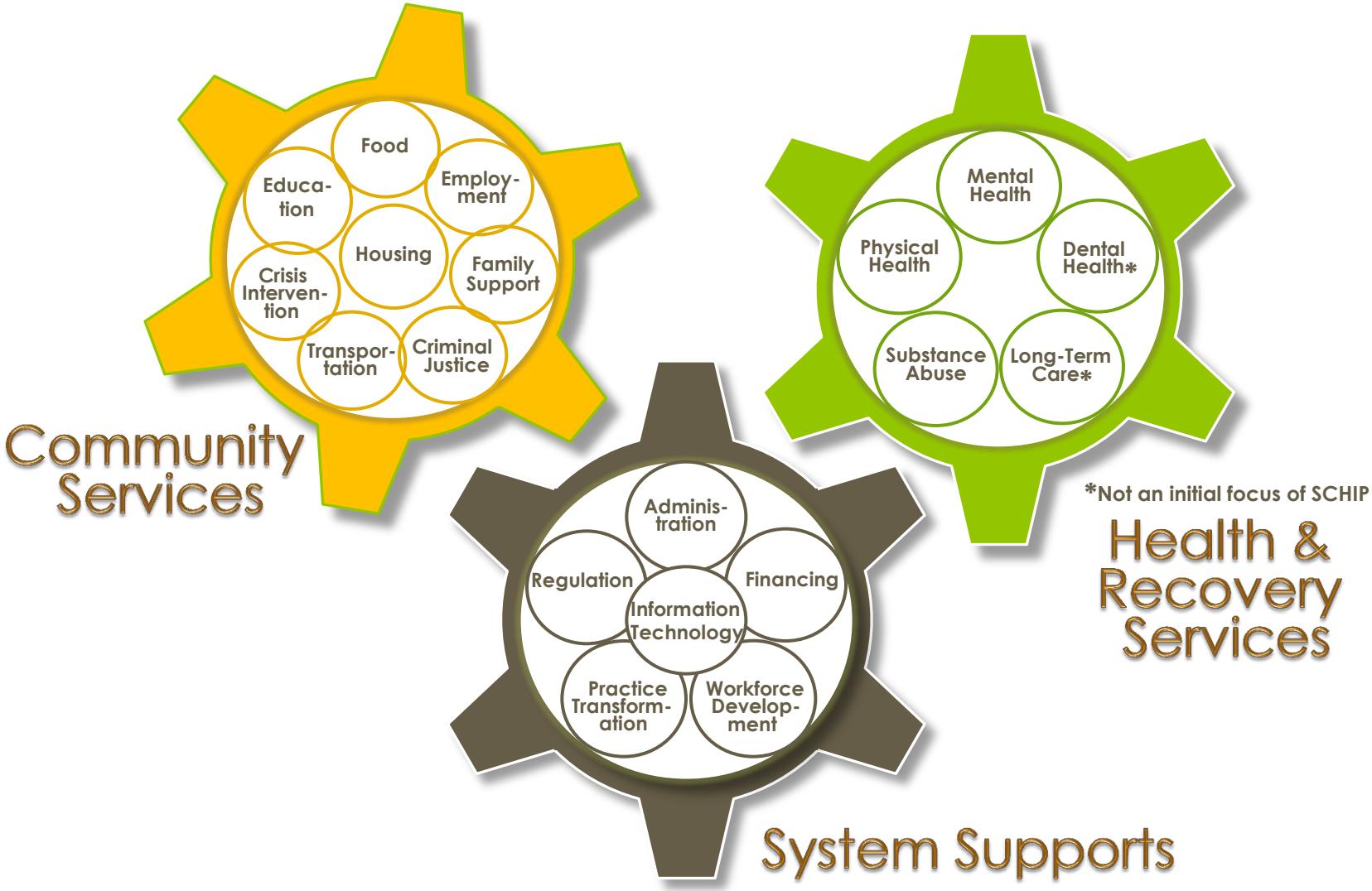
1. **Promote well-being and eliminate systemic barriers to health and recovery** for individuals at risk for or experiencing mental health and substance abuse challenges

2. **Multipayer, purchaser and provider transformation**
   - ❑ Payment approaches supporting coordinated care
   - ❑ Evidence-based care reducing unwarranted variation
   - ❑ Consumer engagement
   - ❑ Infrastructure
   - ❑ Strengthen purchaser alignment/ influence

Busting the Silos

Source: *Busting the Silos—How Integrated Mental Health, Substance Use, and Primary Care Services Can Save Money and Lives* by Dale Jarvis & Associates, April 2011

A Systems Framework for Health



Why Focus on Integration of Physical & Behavioral Health?

Chris Imhoff, Director

Behavioral Health & Recovery, DSHS

- Multi-system perspective based on over 20 years in health care and social services
- Licensed Clinical Social Worker

Defining Our Terms

Definitions are important

- Behavioral health = Mental health + substance use services
- "Integration" refers to clinical delivery systems as well as administrative and financing systems that support the delivery of services

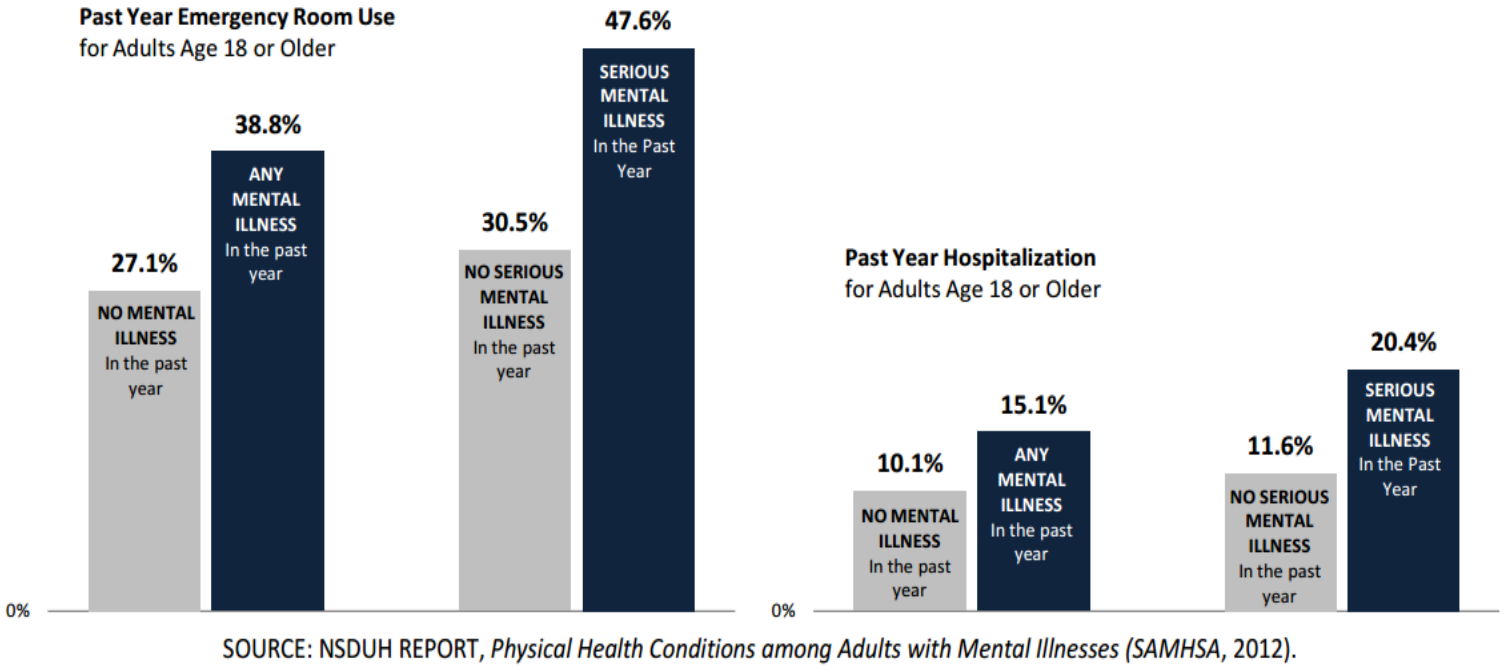
Whole-person care oriented around recovery

- Treating the parts is not an efficient or effective way to serve the person
- Recovery is the process of change through which individuals improve their health and wellness, live a self-directed life and strive to reach their full potential.

Health Disparities

- Americans with serious mental illness (SMI) on average die 25 years earlier than those without SMI and the two leading causes of death are heart disease and cancer
- 1 in 5 Americans experiences a mental illness each year
- Mental illness is common, treatment is effective and people recover
- But…stigma prevents people from seeking help and keeps providers from asking the right questions

Greater Hospitalizations & ED Use



SOURCE: NSDUH REPORT, *Physical Health Conditions among Adults with Mental Illnesses (SAMHSA*, 2012).

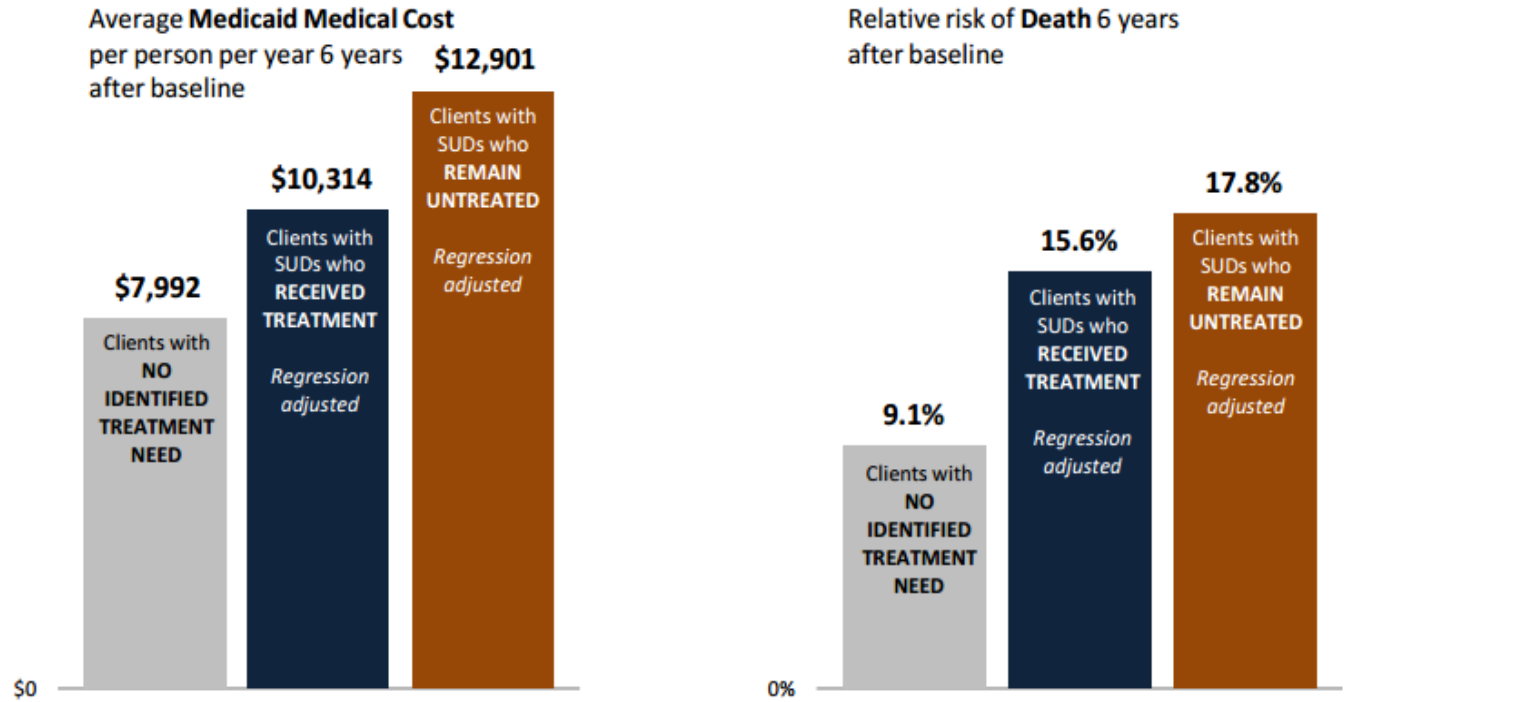
Source: DBHR. November 29, 2012. Adult Behavioral Health System: Making the Case for Change. Olympia: DBHR.

Higher Costs

- Healthcare expenditures for Americans with serious mental illness are 2 to 3 times higher than for others
- Medicaid enrollees with major depression and a chronic medical condition (e.g., diabetes) have more than twice the overall health care costs than those without depression
- Average Medicaid spending on behavioral health for people with schizophrenia is nearly $12,000 + another $5,700 in other health costs vs. an average of $4,000 for other adults

Health Improves and Medical Costs Decline with CD Treatment

Alcohol/drug treatment reduces the risk of mortality, delays the onset of hypertension/cardiovascular disease, and slows the progression of cardiovascular disease for substance users over time.



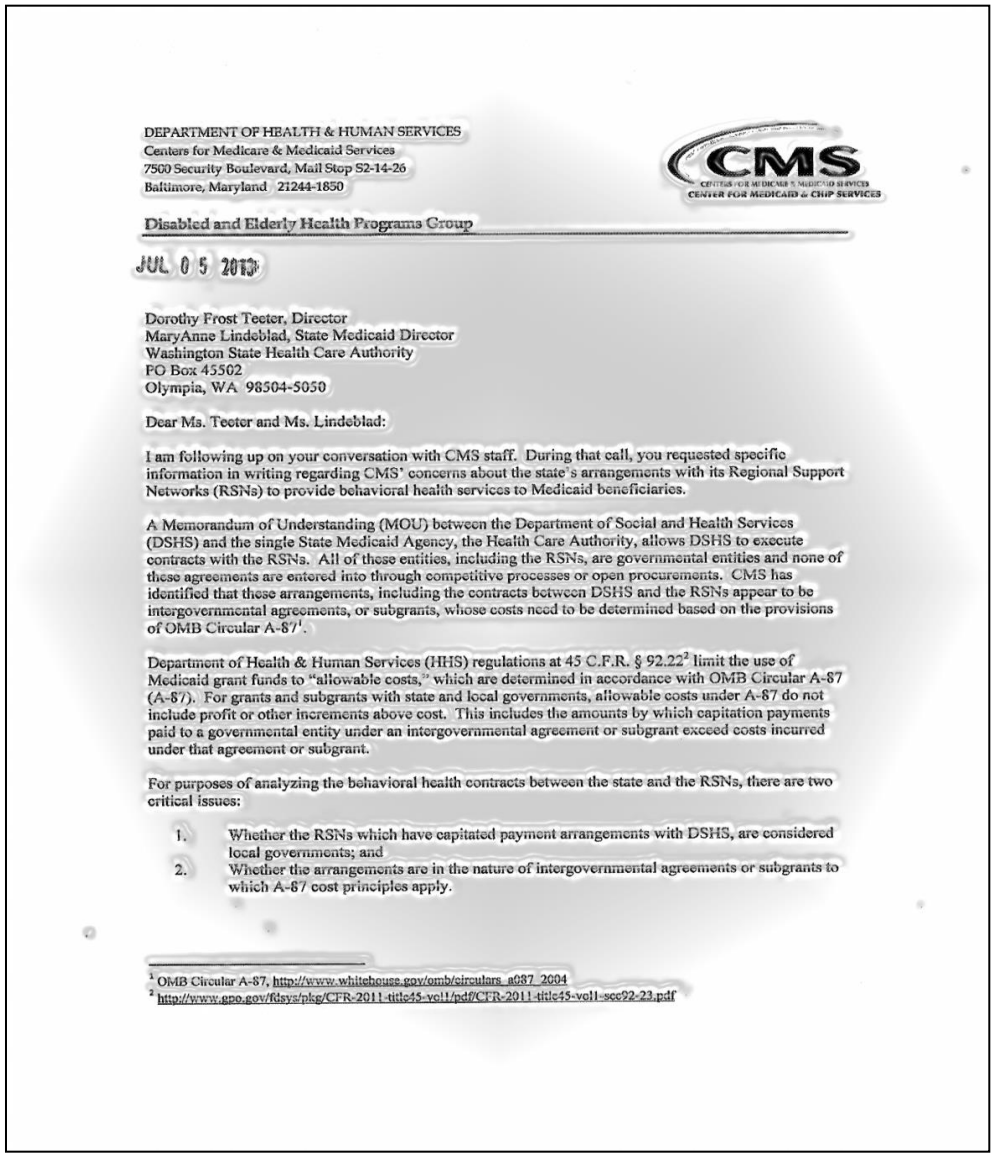
SOURCE: *The Health Impact of Substance Abuse: Accelerating Disease Progression and Death* (Mancuso, Ford Shah, Huber, Felver, 2011).

Source: DBHR. November 29, 2012. Adult Behavioral Health System: Making the Case for Change. Olympia: DBHR.

Ongoing Complementary Efforts

- Common outcomes: SB5732 and HB1519
  - Housing, employment, education
  - Improve health and wellness
  - Reduce criminal justice involvement
  - Reduce avoidable costs in hospitals and emergency rooms
  - Reduce population level health disparities
- Health home services
- HealthPath Washington - managed care pilots in King and Snohomish counties

Where do we go from here?



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Disabled and Elderly Health Programs Group

JUL 05 2013

Dorothy Frost Teeter, Director
MaryAnne Lindeblad, State Medicaid Director
Washington State Health Care Authority
PO Box 45502
Olympia, WA 98504-5050

Dear Ms. Teeter and Ms. Lindeblad:

I am following up on your conversation with CMS staff. During that call, you requested specific information in writing regarding CMS' concerns about the state's arrangements with its Regional Support Networks (RSNs) to provide behavioral health services to Medicaid beneficiaries.

A Memorandum of Understanding (MOU) between the Department of Social and Health Services (DSHS) and the single State Medicaid Agency, the Health Care Authority, allows DSHS to execute contracts with the RSNs. All of these entities, including the RSNs, are governmental entities and none of these agreements are entered into through competitive processes or open procurements. CMS has identified that these arrangements, including the contracts between DSHS and the RSNs appear to be intergovernmental agreements, or subgrants, whose costs need to be determined based on the provisions of OMB Circular A-87[1].

Department of Health & Human Services (HHS) regulations at 45 C.F.R. § 92.22[2] limit the use of Medicaid grant funds to "allowable costs," which are determined in accordance with OMB Circular A-87 (A-87). For grants and subgrants with state and local governments, allowable costs under A-87 do not include profit or other increments above cost. This includes the amounts by which capitation payments paid to a governmental entity under an intergovernmental agreement or subgrant exceed costs incurred under that agreement or subgrant.

For purposes of analyzing the behavioral health contracts between the state and the RSNs, there are two critical issues:

1. Whether the RSNs which have capitated payment arrangements with DSHS, are considered local governments; and
2. Whether the arrangements are in the nature of intergovernmental agreements or subgrants to which A-87 cost principles apply.

[1] OMB Circular A-87, http://www.whitehouse.gov/omb/circulars_a087_2004
[2] http://www.gpo.gov/fdsys/pkg/CFR-2011-title45-vol1/pdf/CFR-2011-title45-vol1-sec92-23.pdf

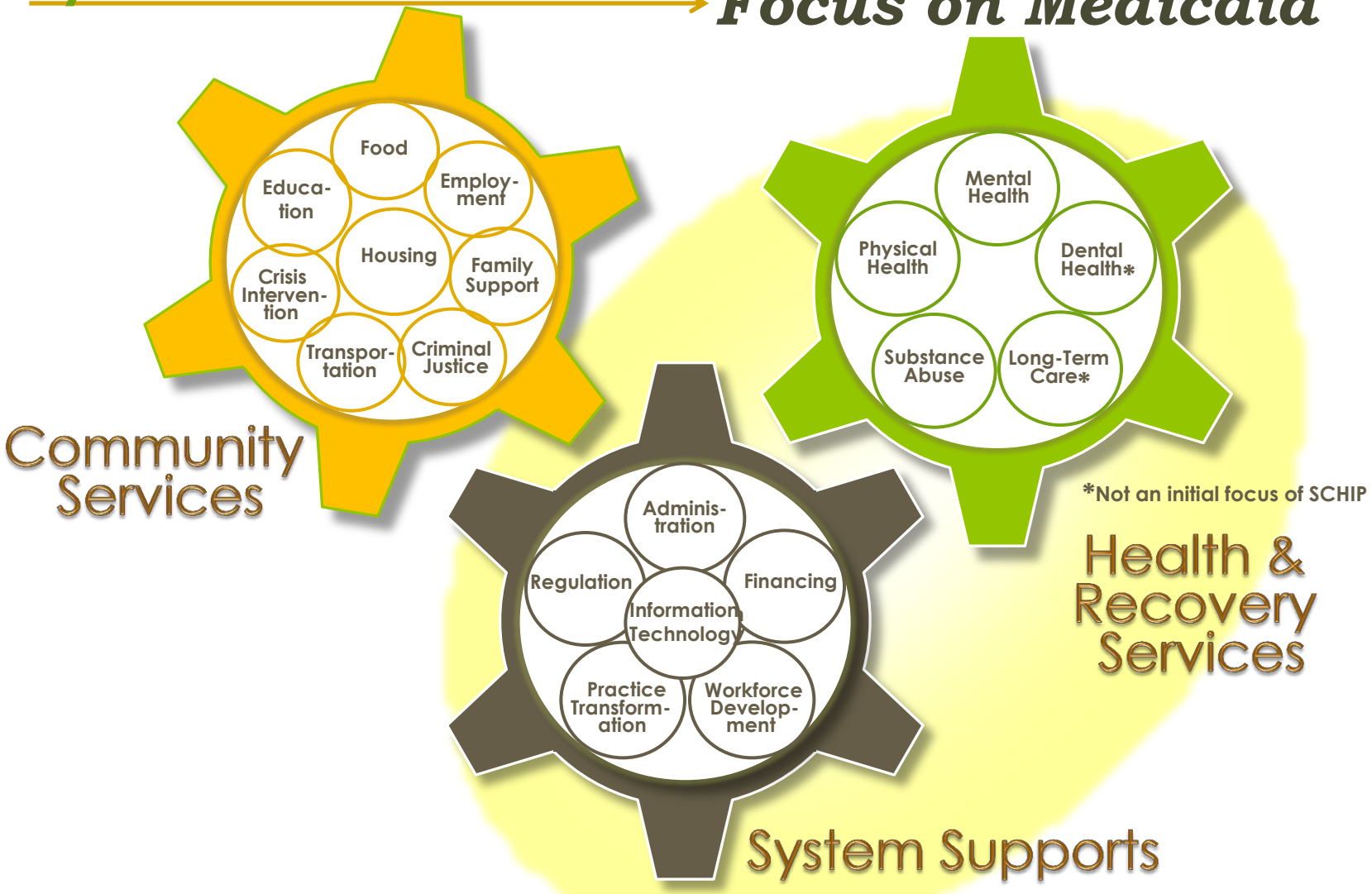
Meet Harry

- Harry is 54, wheelchair bound and on SSI
- His health care is covered by Medicaid
- He has co-occurring physical health and behavioral health diagnoses
  - Major depression, PTSD, and alcohol dependence,
  - Spinal cord injury, type II diabetes, and chronic catheter-related urinary tract infections
- Harry has been homeless for the last 12 months
- He has a childhood history of physical abuse

How well do we serve Harry?

- In the past 15 months Harry has made 78 Emergency Department visits – primarily to treat his chronic urinary tract infections
- He is frequently intoxicated, but not engaged in chemical dependency services
- He has no connection with a primary care provider
- His only mental health services have been crisis intervention contacts in the Emergency Department, when he's intoxicated
- He doesn't show up for follow-up mental health (or other) appointments
- No one reaches Harry – he's hard to find and his priority is actually housing

Systems Framework → *Focus on Medicaid*



Systems to Support Integrated Physical & Behavioral Health Care

Jonah Frohlich
Managing Director, Manatt Health Solutions

Representing the Manatt Team:

- Deborah Bachrach
- Sandra Newman
- Andrew Detty

Definitions of Integration

We use the following definitions of integration, adapted from the Agency for Healthcare Research and Quality's *Lexicon for Behavioral Health and Primary Care Integration*:

Integrated Provider Program

- Organizational structure that ensures availability of staff and linkages with other programs to address all patient needs, including interventions for physical health, mental health, and substance use disorders, through interactions between providers

Integrated System

- Organizational structure that supports array of programs for individuals with different needs through funding, credentialing, licensing, data collection and reporting, needs assessment, planning, and other operational functions

We use the term "**coordination**" to refer to working relationships, information exchange, and shared planning and decision-making among separate entities and individuals.

We use the term "**integration**" to refer to coordination among entities and individuals under shared governance or administrative structures, or in shared physical space.

The Question:

The Whole Person

Physical Health, Mental Health, and
Chemical Dependency Needs
Driven by Underlying Social Determinants of Health

Providers

Physical Health Providers	Mental Health Providers	Chemical Dependency Providers

Systems of Care

Physical Health System	Mental Health System	Chemical Dependency System

Administration

Physical Health Administration	Mental Health Administration	Chemical Dependency Administration

What system structures will support integrated care delivered by providers to people with physical and behavioral health needs?

Administration and Oversight of Medicaid Benefits
2 State Agencies; 39 Counties; 29 Tribes

Administering Entity	Medicaid Benefits
Health Care Authority (HCA)/ State Medicaid Agency	▪ Physical health ▪ Limited mental health (12/20 visits) ▪ Prescription drugs (excl. opiate substitution) ▪ Targeted health home services (high cost/high risk)
Department of Social and Health Services (DSHS)/ Division of Behavioral Health and Recovery (DBHR)	▪ Chemical dependency (inpatient and outpatient) ▪ Mental health for people with serious mental illness (SMI), through Regional Support Networks
Department of Social and Health Services (DSHS)	▪ Long-term services and supports ▪ Supports for people with developmental disabilities ▪ Targeted health home services (high cost/high risk)
Counties (under contract with DSHS/DBHR)	▪ Regional Support Networks (as single counties or county partnerships) ▪ Outpatient chemical dependency
Tribes	▪ Outpatient mental health ▪ Outpatient chemical dependency (under contract with DSHS/DBHR)

Stakeholders Interviewed

- Community Health Centers
- Community Mental Health Agencies
- Consumers
- County Chemical Dependency and Social Services Departments
- HCA and DSHS Representatives
- Healthy Options Plans
- Legislative Staff
- Researchers
- RSNs
  - Single-County
  - Multi-County
  - Private

3 Systems of Care, Multiple Levels of Government, 1 Person

Mental Health for People with SMI
Administered by DSHS/DBHR and RSNs

DSHS administers services for people with SMI who meet Regional Support Network (RSN) Access to Care Standards

- DSHS contracts with RSNs for mental health services
- State hospitals provide intensive psychiatric inpatient treatment

Providers

Physical Health & Mental Health for People without SMI
Administered by HCA

HCA administers physical health services, including prescription drug coverage, for all Medicaid enrollees in all systems of care

- HCA contracts with Healthy Options (HO) plans for Medicaid managed care enrollees
- HCA contracts directly with providers for fee-for-service (FFS) enrollees

HCA administers mental health benefits for enrollees who do not meet RSN Access to Care Standards

- HCA contracts with HO plans for MMC enrollees
- HCA contracts directly with mental health providers for FFS enrollees

Providers

Chemical Dependency
Administered by DSHS/DBHR and Counties

DSHS administers chemical dependency services for all Medicaid enrollees

- DSHS contracts with counties and tribes to provide outpatient services, including opiate substitution treatment
- DSHS contracts directly with residential treatment agencies to provide residential services

Providers

The Whole Person

Integration at the System Level

Minimal Coordination	Basic Coordination	Close Coordination	Full Integration
▪ Have separate systems	▪ Have separate systems	▪ Some shared systems and workarounds	▪ Function as one integrated system
▪ Limited understanding of each other's roles and resources	▪ Appreciation of each other's roles and resources	▪ Understanding of each other's roles and culture	▪ Roles and cultures that blur or blend
▪ Rare communication, typically under compelling circumstances only	▪ Period communications about shared patients, driven by specific patient needs	▪ Frequent communication and collaboration	▪ Consistent communication and collaboration
▪ Physical and behavioral health needs treated as separate issues	▪ Physical and behavioral health needs treated separately	▪ Physical and behavioral health needs treated collaboratively for certain sets of patients	▪ Physical and behavioral health needs treated collaboratively for all patients
▪ No coordination or management of collaborative efforts	▪ Some leadership efforts around systematic information sharing	▪ Leadership support for integration through mutual problem-solving	▪ Leadership support for integration as driving model of operations
▪ Separate funding streams, billing practices and no resource sharing	▪ Separate funding streams and billing practices with some shared resources	▪ Blended funding streams, with some shared expenses and combined billing	▪ Integrated funding, with shared resources, expenses and integrated billing

While there are some instances of integrated service infrastructure, Washington's overall physical, mental health and substance abuse service systems largely support "basic coordination" at the administrative and system levels.

Note: Levels of integration adapted from the SAMHSA-HRSA Center for Integrated Health Solutions' *A Standard Framework for Levels of Integrated Healthcare*

Beyond the Status Quo: Options for Washington

1

Resolve Major Obstacles, Leave Existing Systems Largely Intact

- Retain current division of responsibility between Healthy Options, RSNs, counties
- Competitively procure contracts;
- Resolve system impediments to better coordination and integration including:
  - Data sharing
  - State reporting infrastructure
  - Streamlined / coordinated assessment tools
  - Aligned and simplified regulatory requirements
  - Strengthen requirements and accountability (including incentives and penalties) in state contracts

2

Integrate Mental Health and Chemical Dependency Systems

- Establish behavioral health organizations (BHOs) with responsibility for MH *and* CD
- Carve out & manage all CD and BH benefits in BHOs
  - Provide counties with first right to contract for BH/CD services
  - Require BHOs (and physical health systems) to coordinate with county services (e.g., jails, courts, EMS)
- Sustain local resources and linkages to BHOs (e.g., housing, crisis response, health promotion)
- Develop stringent coordination and data sharing requirements subject to incentives and penalties between BHOs and physical health systems

Example: Pennsylvania HealthChoices

3

Centralize Responsibility for all MH, CD & Physical Health

- Accountability for full spectrum of physical health, MH, and CD services in risk bearing entities (accountable communities of health)
- Competitively procure contracts, considering global capitation, shared savings or other risk bearing arrangements supported by subcontracts as warranted
  - Reinvest savings
  - Consider special arrangements for targeted populations (e.g., dual eligibles, people with SMI)
  - Define performance requirements, incentives and enforceable penalties
- Define sustainable community level resource linkages

Example: NY Medicaid Managed Care, OR CCOs, MN Hennepin

Lower **Level of Integration and System Change Effort** ***Higher***

State Integrated System Models: High-Level Summary

	Short Description	*Single entity for physical, MH and CD*	*Carve Outs*	*Coordination*
MN	▪ Medicaid Health Care Delivery Systems are accountable for physical, MH and CD services ▪ Integrated delivery systems with 2k+ patients are eligible for shared savings and shared risk	Yes	None	▪ Delivery systems must incorporate formal and informal partnerships with community and social supports
NY	▪ Eliminated MH/CD carve-out; plans unable to meet MH/CD requirements must contract with qualifying BHOs ▪ Enhanced quality metrics	Yes	None	▪ Care plans must integrate non-plan services (e.g., housing)
OR	▪ Eliminated MH carve-out; Coordinated Care Organizations (CCOs) receive capitated payments to provide physical, MH and CD services ▪ Governance must include MH or CD provider	Yes	Mental health drugs	▪ CCOs develop community health assessments and improvement plans working with local entities
PA	▪ Physical health delivered through MMC; mandatory in all counties with several exemptions (e.g., full-benefit duals, Aging Waiver) ▪ Counties have "right of first opportunity" to administer BH; two-thirds of counties have selected this option	No	MH, CD, Methadone	▪ Physical and BH MCOs must develop and implement written coordination agreements ▪ Established coordination pilots under common state framework for integrated care

Examples of Washington's Experience with Bi-Directional Integrated & Coordinated Care

Washington can draw upon a number of programs that have been working towards integration of physical and behavioral health services

Behavioral Health in Primary Care Settings

- Mental Health Integration Program (MHIP)
  - Integrates mental health screening and treatment into community health centers statewide through a collaborative approach including a PCP, a care coordinator, and a consulting psychiatrist
- COMPASS
  - Leverages collaborative care management models to treat adults who have depression and diabetes and/or cardiovascular disease, in primary care settings
- Community Health Centers
  - Many provide collocated and coordinated physical health, mental health, and chemical dependency services
- Kitsap Mental Health Services
  - Provides psychiatric consultant services for Kitsap-area PCPs
  - Provides brief behavioral health intervention services at four primary care sites

Primary Care in Behavioral Health Settings

- SAMHSA Primary and Behavioral Health Care Integration (PBHCI) project sites
  - Navos
  - Asian Counseling and Referral Services
  - Downtown Emergency Service Center
- Kitsap Mental Health Services
  - Collocates a primary care provider on-campus to provide services to individuals with significant physical and behavioral health needs
  - Offers multi-disciplinary Adult Outpatient Care Teams, using federal grant funds to support medical assistants providing linkages to primary care
- MultiCare Good Samaritan Behavioral Health
  - Provides primary care at Pierce County community mental health agencies through a mobile van staffed by a primary care team
- Other Community Mental Health Agencies
  - Several agencies partner with PCPs to offer services on-site, some through relationships with FQHCs and hospitals

Current System Strategies Being Demonstrated

	Short Description	*Single Entity for Physical, MH and CD*	*Carve Outs*	*Coordination*
HealthPath Managed Fee-for-Service Health Homes Demonstration ("Strategy 1")	▪ Provide care coordination services to Medicaid recipients, including but not limited to dual eligibles, with: multiple chronic conditions; has one chronic condition and is at risk of developing another; or has one serious and persistent mental health or CD condition. ▪ HCA and Healthy Options plans make PMPM payments to Health Home Lead Entities (e.g., MCOs , RSNs, providers) ▪ Lead Entities subcontract with provider networks including Care Coordination Organizations (e.g., MCOs, RSNs, providers) that deliver services	No (New Medicaid service for coordination across systems)	N/A	▪ Services include care management and coordination, health promotion, transitional care, patient and family support, referrals to community and social support services, use of HIT to link services ▪ Care Coordinators employed by Care Coordination Organizations work with recipients to develop Health Action Plans, which are incorporated into care plans across service sectors
HealthPath Washington Capitated Demonstration ("Strategy 2")	▪ Proposed demonstration project for dual eligibles in King and Snohomish counties ▪ Pending final MOU and roll-out, Medicare-Medicaid Integrated Health Plans (IHPs) will receive capitated payments to provide Medicare and Medicaid services, including physical health, MH, CD, and LTSS	Yes (and LTSS)	None	▪ IHPs must provide beneficiaries with an inter-disciplinary care team which includes a community-based care coordinator ▪ Coordination required with services outside the plan's financial responsibility (e.g., adult protective services, crisis services, detox, involuntary treatment, State Hospital services) ▪ Counties played a significant role in developing contract requirements

Applying Lessons Learned to a New Integrated and Coordinated Physical and Behavioral Health System for Washington

An integrated system in Washington must . . .

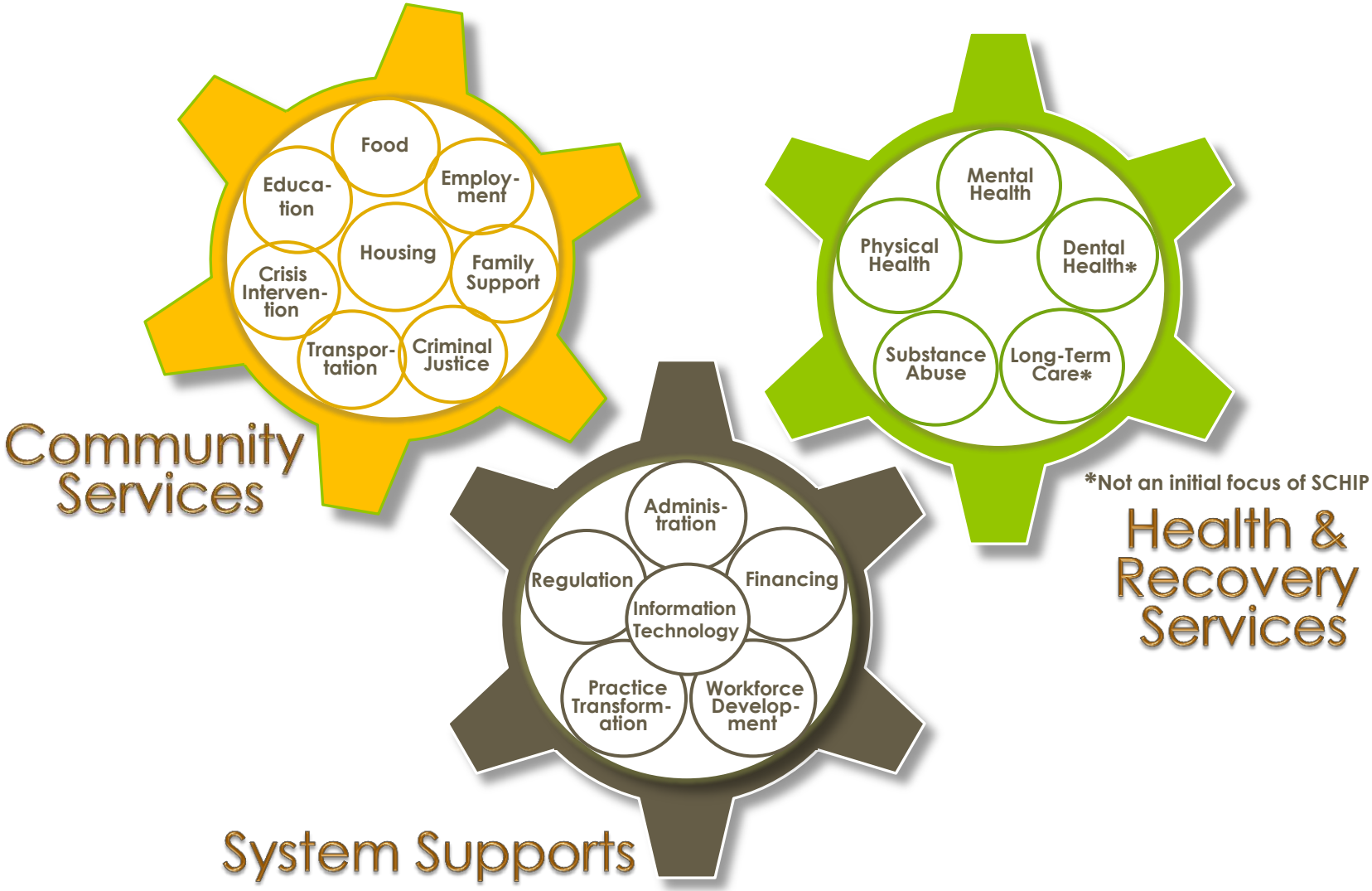
- Align currently fragmented administrative and financing structures
- Promote payment methodologies that incentivize integrated care
- Hold contracted entities accountable for outcomes for the whole person
- Improve “real-time” data sharing across provider types
- Align provider licensing and professional requirements across systems
- Support better care coordination
- Define a role for communities in governance, accountability and financing to ensure that the system addresses local needs
- Include local social services and community entities as key partners

Roles Beyond the Health Care System

Jonathan Seib
Senior Vice President,
Healthcare, Strategies 360

Tom Byers
Founding Partner,
Cedar River Group

How do/could these systems support Harry?



Questions & Feedback

Next Steps

- **Focused strategies & tactics** are in analysis phase—*nothing finalized*
- **An outline of the draft plan** will be available at: http://www.hca.wa.gov/shcip/Pages/default.aspx
- **Sign up for the Feedback Network** to receive updates: simquestions@hca.wa.gov
- **Next webinar** is October 15, 11 am-12:30 pm. Register at: https://www2.gotomeeting.com/register/444595962

Thank You

Contribute to Innovation Planning:

Sign up to be part of the SHCIP Feedback Network:
Email your interest to **simquestions@hca.wa.gov**

Stay informed via the SHCIP website:
http://www.hca.wa.gov/shcip/Pages/default.aspx

Share your thoughts by emailing the SHCIP Help Desk:
simquestions@hca.wa.gov